

Medication Request Form (MRF)
COMMUNITY HEALTH GROUP
c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10680 Trenea Street, Suite 500
San Diego, CA 92131
Phone: 1-800-788-2949
Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:

This form is to be used by participating physicians and providers to obtain coverage for a non-formulary drug for which there is no suitable alternative available. Please complete this form and fax to **MedImpact Healthcare Systems, Inc.** at (858) 790-7100 or call (800) 788-2949 with this information. If you have any questions regarding this process, contact **MedImpact's** Customer Service at (800) 788-2949.

Review Criteria:

The following criteria is used in reviewing medication exceptions:

1. The use of Formulary Drug Products is contraindicated to the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

Medication Request Information (please complete each section of this form prior to transmittal):

DATE OF REQUEST: _____

<u>Patient Name (required):</u>	<u>Patient's Health Plan (required):</u>
<u>Patient ID # (required):</u>	<u>Physician Name/Specialty:</u>
	<u>Physician LIC# (required):</u>
<u>Patient DOB (required):</u>	<u>Physician Area Code and Telephone Number:</u> () -
<u>Diagnosis (required):</u>	<u>Physician Area Code and Fax Number (required):</u> () -
<u>Pharmacy used by Member:</u>	<u>Pharmacy Area Code and Telephone Number:</u> () -
<u>Drug Requested:</u>	<u>Quantity (per month):</u>
<u>Dose:</u>	<u>Length of Treatment (please be specific):</u>
<u>Strength:</u>	<u>Dosage Form</u> (e.g. Oral, Injection)
Reason for Medication Request Required (please be specific, give detail):	
Other Medications Tried and/or Failed Required (please be specific, give detail):	
Other Pertinent History (relative or pertaining to this request):	